AUTHORIZATION BY PATIENT FOR RELEASE OF MEDICAL INFORMATION

THIS AUTHORIZATION FORM IS COMPLIANT WITH TENNESSEE AND FEDERAL PRIVACY LAWS, INCLUDING THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

Section A:

I, the individual identified below, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: CHRISTIE ANDREWS	**Social Security Number:**
	Date of Birth:
Persons/organizations authorized to receive the information: **The Swafford Law Firm, PLLC** 321 Billingsly Court, Suite 19 Franklin, TN 37067 **OR THEIR REPRESENTATIVE**	**Personal Organizations authorized to disclose information include:** **Doctors, hospitals, psychiatric or psychological facilities, any and all health care facilities, long term care facilities, drug stores, nursing homes, out-patient care facilities, medical laboratories, and ambulance services and providers and any medical billing facilities for any of the above.**

Specific description of information (including dates(s)) authorized for release: Copies of any and all records, opinions, notes, reports, x-rays, charts summaries, abstracts, psychiatric or psychological or venereal disease test results, invoices, statements or other documents, records or information in your custody or control (collectively, the "records") arising from such examinations, care, treatment, counseling, or testing of the individual from January 1, ~~2015~~ 2016 **through Current.** The above firm's agents and employees are also authorized to inspect the originals of all such records.

What is the purpose of the use or disclosure?: For use solely for the purpose of defending the litigation brought by the patient or involving the patient.

Section B:

The patient or the patient's representative must read the following statements:

1. Unless otherwise revoked, I understand that this authorization will expire on the later of December 31, 2025 or with the following event: at the conclusion of this case, whether by trial, settlement or other conclusion.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but such revocation will only be effective from the date it is received and will not apply to information that has already been released in response to this authorization.
3. Your health care provider or health plan will not prohibit or prevent your treatment, payment, enrollment in a health plan or eligibility for benefits if you refuse to sign this authorization.
4. A photocopy of this authorization has the same force and effect as the original executed authorization.
5. I understand that I will be given a copy of this authorization form after it is signed.

_____ _____

Signature of patient or patient's representative **Date**
(*Form MUST be completed before signing.)*

Printed name of patient or patient's representative: _____

Description of such representative's authority to act for the patient, if applicable: _____